

Second Line Drug Program Eligibility Worksheet

Client Name _____ DOB _____
 District _____ PHN _____ Phone _____

TO BE COMPLETED BY DTBNH or TB Nurse Case Manager

Client on DOT and case-managed by LHD? ☐ yes ☐ no

Transferred case ☐ yes ☐ no From where _____ on (date) _____

Treating clinician _____

Alternate regimen due to (check what applies) ☐ resistance ☐ intolerance

If due to intolerance, was reintroduction of first line drugs attempted? : ☐ yes ☐ no

If not, why? _____

Test	Date/Result
Smear	
GeneXpert/NAA/PCR	
Culture	
Susceptibility/resistance	
QFT/PPD	
CXR	
Histology	

Drug prescribed: start date _____ DOT: ☐ yes ☐ no If no: Reason _____

Initial and/or revised treatment	Dosage (mg)	Start date	Stop date	Reason for rifabutin or second-line drug

Does client have source of free medications (DOD, DOC, Veterans Admin., MA, etc.)? ☐ yes ☐ no

Additional information supporting need for rifabutin and/or second line drug
